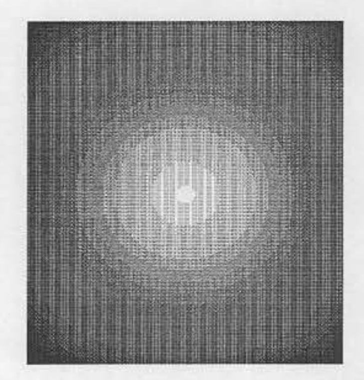


Bulletin of



Experience

Volume 2, Number 1
January 1991



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Bulletin of Anomalous Experience is a networking newsletter about the UFO "Abduction" phenomenon and related issues for interested scientists and mental health professionals.

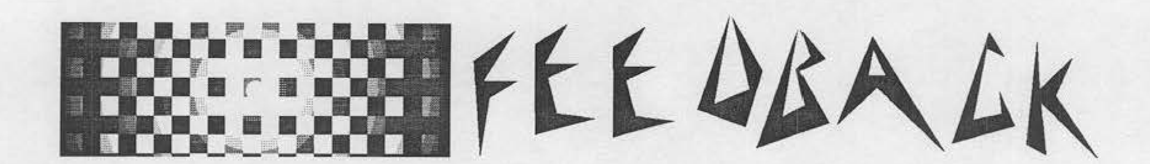
BAE provides a forum for dissemination of information and insights, and ongoing debate. If you have something to say, here is a place to say it. If you have a question or a problem, here is a place to ask for help.

BAE is contribution-driven, and I see my role not as an editor but as a chairman of a series of ongoing, parallel discussions. Editorial comments and introductions are identified by italics.

When you're done with this issue, write me! Tell me what you think of this issue. What topics do you think should be covered? Is there a role for BAE at all? If you prefer to be anonymous, that's perfectly fine. Remember, I know where you all live.

Distribution is limited to mental health professionals and interested scientists. Requests for subscriptions (at $20 per year, a real bargain!) are welcome. (Cash or money orders would be preferred to cheques -- my bank charges big bucks to deal with cheques drawn on U.S. banks.) Write to

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From Richard Neal:

"I was interested in the last page on Conception and Birth. I have researched this so-called missing Embryo/Fetus Syndrome over the past three years. Hopkins, Strieber and Jacobs all claim to have numerous cases -- however, when confronted to have referrals as well as OB/GYN physicans medical records for follow-up --no one can seem to come up with one referral. Needless to say, I am extremely reluctant to believe that this is happening. Of the three cases I have researched here in Southern California all have a reasonable obstetrical explanation as related to a complication of pregnancy."

from Leo Sprinkle:

Vol 1, No 7 Nov 1990 BAE is excellent; keep up the good work.

I have a comment about Dr. Haines' Code of Ethics (which is excellent!):

I encourage clients to bring a witness, for suport, during hypnosis sessions. And, as Dick states, an impartial witness can be helpful in the conduct of the session and interpreation fo the results.

However, over the years, I have worked with many persons who -- like other clients for professional services -- wish to conduct the sessions without others. In those situations, I choose to follow the wishes of the client in order to favor the therapeutic, rather than the research, goals.

Hilary Evans, who this issue joins our virtual community, took issue with my comments from #7 on Robert Baker's article from Journal of UFO Studies #1 (1989) *called "Q: Are UFO Abduction Experiences for Real? A: No, No, a Thousand Times NO!"*

I think you are being unjust to Dr. Baker in your phrase: "The experiencers I see ... deserve better than to be dismissed as a group by academics with little or no working experience with 'abductees.'"

I deplore, first, your use of the word 'dismiss.' I don't see that providing an alternative interpretation of someone's claims is equivalent to dismissing them. What Dr. Baker is saying, surely, is that for him the evidence that abductions are occurring on the physical level is inadequate, and that he finds it easier to accept an alternative, psychological, account of what these people are experiencing. To propose that their experience is hallucinatory by nature is not the same as dismissing it as being no experience at all; rather, it is saying that it is an experience of a different kind.

Secondly, I am unhappy about the implication that only those who have 'working experience with "abductees"' have the right to speak out in this matter. I cannot speak for Dr. Baker, of course; yet I feel it likely that he, like me, is speaking out in this matter only because he is unhappy with the published pronouncements of those who are so working.

So what should we do, David: Keep our unhappiness to ourselves? Yes, indeed, if we have no more than that to offer. But Dr. Baker has more, he has an alternative interpretation. That interpretation may not be based on working with 'abductees,' but it is surely derived from his career experience of human behavior.

As for myself, I do not have even Dr. Baker's professional experience to back me: I have met many people who claim a wide variety of abduction and otherworldly encounter experiences, but I have not 'worked' with them for the very good reason that I have neither the competence nor the moral right to do so. So should I conclude that neither do I have the competence or the moral right to express my views on the matter?

I dare say I would indeed keep quiet, if I could see that those who do possess 'working experience' with 'abductees' are seriously considering the psychological alternatives. But I see no sign that they are doing so: The only people I see considering alternative views are others who, like myself, are unhappy with what we're being fed by the 'abductionists.' Under these circumstances, I for one feel it right to speak, despite my lack of hands-on experience. I make no assertions: I do not seek to impose my views. If these views are mistaken, I shall expect to be told so. But I shall need somewhat more evidence than the unsupported assertions of improbable adventures by people whose life histories --even as publicly published, let alone what never goes beyond the consulting-room walls -- give good grounds for interpreting their reports as psychological fantasy rather than physical fact.

The following is my response.

My reading of Baker's opinions was that he felt (1) Convincing evidence that abductions are occuring as a physical reality is lacking, therefore he rejects this premise. I don't have much of a problem with this. I myself would require pretty convincing physical evidence to accept the ET hypothesis. However, he also appears to say (2) abduction experiences are (almost) all explainable as hallucinations, personality disorders and boundary-deficit cases.

This is where it starts to get confusing for me. For instance, which abduction experiences? What data base are we talking about? We don't have a common frame of reference. I agree that the highly publicized cases aren't airtight enough to make a case for a psychologist, because although the stories themselves are compelling the central figures often leave open the possibility of more prosaic explanations (whether or not the more prosaic is the correct one is not important).

But the community that reads BAE, to say nothing of the communities that are involved in groups like the Spiritual Emergence Society, ISSSEEM, and the Society for Scientific Exploration, encounters clients for whom the prosaic explanation appears to be inadequate. It is the frequent encounters with cases defying existing paradigms that has created and perpetuates groups like those mentioned above.

Highly publicised cases are meaningful only insofar as they highlight the possible existence of a poorly-understood experience, and encourage its further study. I don't think they should be taken for any more than that. In particular, I think that too many professional people tend to ignore the importance of these observations because they are put off by the exotic explanations.

Most of the anomalous experience patients in my practice have told me that they are NOT at all interested in publicity or media appearances of any kind. They are willing to participate in bona fide scientific studies of this phenomenon. The ones that do "go public" represent a particular subset of experiencers, and maybe a bad subset to present to the general public or the scientific community, because of the possibiltity (that may be inferred by critics, whether or not actually present) of secondary gain or other psychological explanations.

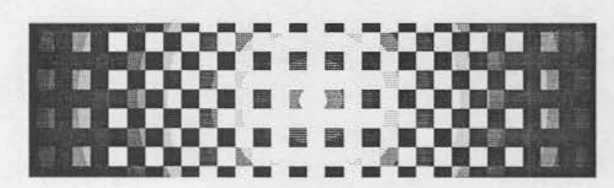
What is needed, as I have said before, is a scientifically meaningful study of cases from a medical/psychological perspective, to answer the question, "What are these people experiencing?" This is the crucial question for me, not "Are these people being abducted by aliens?" That's why this newsletter is called Bulletin of Anomalous Experiences, not Bulletin of Abduction Experiences -- a very deliberate move on my part.

Dr. Baker, by my reading, was not simply offering an alternate explanation for abduction experiences, he was making a conclusion that these experiences "can and do account for most, if not all" of the abduction reports. On what basis? If you are going to say that the abductee population as a whole has a particular psychological problem (especially problems like personality disorders, which carry with them the implications of pervasive personality dysfunction and poor prognosis), it is only reasonable that you should have some first-hand experience with a representative sample of that population. Discussing a handful of popularized cases is not enough.

Please, present alternative explanations, as prosaic as they can be -- especially when these have not been considered. You don't have to be a clinician to do that. Criticise what is written, point out the erroneous conclusions. That is why the BAE readership is not limited to clinical workers. They are welcome. Indeed, that is much of what I have tried to do in BAE (witness our discussions on temporal lobe epilepsy).

But the field is still too raw to make absolute pronouncements about the source of these experiences in all subjects, and by implication suggesting treatment for disorders that may not necessarily be present, without the clinical work being done. And it has not been done in a coherent way yet. (Until we organize our clinicial information into a credible package, maybe we should be less strident in complaining about our detractors). One reason the work has not been done yet is that people like Dr. Baker say that there is no reason to look for another explanation. I disagree.

Finally--a debate! Opinions?



"STUFF"

A collection of news and random bits of information.

A Study of PTSD in Abductees

Noted in the latest Quarterly Report of the FUFOR was a proposal by Dr. Leslie E. Wong of the Evergreen COllege in Olympia Washington, for the study of PTSD in abductees. "The proposal would involve followup research of 50-60 respondents to a questionnaire-based pilot study of abductees undertaken by two students at the college earlier in 1990. The purpose of the study is to determine whether the abduction phenomenon causes PTSD in some abductees."

I have written Dr. Wong to see what more I can find out about his work and this project.

University Course on UFOs

Stanton Friedman sent me a notice of the following course, offered by the University of North Dakota, Division of Continuing Education, which I reproduce below:

IS 379: Special Topics: UFOs, ETs & Close Encounters

2 Undergraduate Credits

Instructor: Dr. John Salter

John R. Salter, Jr., Professor and Chair of Indian Studies, is MUFON State Director for North Dakota and a member of the Canadian UFO Research Network. His conscious interest in UFOs began after he and his son, John III (then a UND graduate student) were intercepted by friendly UFO humanoids in southwestern Wisconsin in the evening of March 20, 1988, subsequently having a cordial and fascinating 1 1/2 hour meeting with them; the next day, while in Illinois the UFO descended to about 200 yards in front of their pickup for a friendly gesture of "Adios."

This course, intended to be a sensible approach to the UFO phenomenon, accepts the reality of UFOs and their extra-terrestrial origins. It is not a course in mysticism, theology or parapsychology. (However, some parapsychological approaches are used by the "aliens". Humans sometimes find THEIR psychic faculties enhanced after an encounter, and these facets will be explored). The basic format of the course will be lecture and discussion but there will be several films and certain primary materials (such as hypnosis tapes); several encounters (eg Betty/Barney Hill, John Salter and son) will be discussed in great detail.

Other topics of discussion include UFO technology. close visual sightings, physical traces of UFOs, and seeing the aliens.

"A sensible approach to the UFO phenomenon (that) accepts their extraterrestrial origin" sounds to me like an oxymoron, though I'm sure some of you will disagree.



Hilary Evans

59 Tranquil Vale

London SE3 OBS England

I am a (picture) librarian by profession, and began my career as an advertising copywriter after getting master's degrees in English Literature at Cambridge and Birmingham. That is the extent of my qualifications, giving me no right to pontificate on matters psychological, sociological or any otherlogical. So I don't pontificate: I merely offer suggestions, based on a lifelong curiosity as to why people behave as they do, and particularly, why do they believe the unbelievable things they believe? This, in turn leads, of course, to a search to determine whether the unbelievable things are really as unbelievable as they seem to be, hence an interest in things paranormal, from UFOs to encounters with the Virgin Mary.

I have written several books and articles on these subjects. My most important books are Visions, Apparitions, Alien Visitors (1984); Gods, Spirits, Cosmic Guardians (1987); and Alternate States (1989). These have encouraged skeptics to believe me a believer, believers to think of me as a skeptic: Suggesting, to me at any rate, that I've got it about right. I am a Council Member of the Society for Psychical Research.

My provisional views on the subject-matter of your project are that UFOs as alien spacecraft do not exist; and as a consequence, that no human beings are being abducted by alien entities. I am prepared to alter these views the moment anyone offers me convincing evidence to the contrary; but right now I feel there are psychosocial explanations which are more probable. I recognise, though, that these explanations are pure speculation, and have only their probability to justify them.

I draw my support for these views from two main sources. First, the experience of witchcraft in the 15-17th centuries, together with other epidemic outbreaks of mania such as the dancing mania, religious revivalism in 19th century America, and so on. And second, the experience of medical men -- particularly Pierre Janet -- in their exploration of psychological disorders.

At the same time, I do recognise the existence of powers and forces transcending those normally accepted by science. I have little doubt that telepathy and precognition occur, and I am fairly confident that psychokinesis occurs too.

This is perhaps the appropriate moment to mention my own current project, SLIDE - Street Lamp Interference Data Exchange (see elsewhere in this issue). What excites me about it is that it is more-or-less unexplored territory, so that witnesses are unlikely to be contaminated by what they've read or heard; and also that the phenomenon is of such a nature that trickery is virtually out of the question. The material I have so far collected encourages me to think that this is a research-area of immense potential; at the same time, simply by inititating the project I am clearly bringing great peace of mind to people who thought they were the only people to have this kind of experience.

One of my concerns about the TREAT approach is my feeling that while abductees (for instance) evidently need treatment, until we know whether their experiences have a basis in fact, we can't know how to treat them.

It's all very well your saying glibly that 'the health etc. of the experiencer must always take priority over the collection of data and the solving of the mystery' *(A reference to my Pensacola MUFON paper on medical and ethical issues in abduction research -- David)* -- but the two can't be separated, any more than you can heal a medical patient until his ailment has been diagnosed.

Yes, you can wrap him in warm blankets and mop his fevered brow; but you can't administer medication or surgery until you know what to prescribe or where to stick the knife.

Suppose a girl complains she's been raped: She needs our comfort and support -- but the way we comfort and support her will be different depending on whether she was really physically attacked by a real-life nasty, or whether she is fantasising the event as a way of working out some private hang-up festering inside her.

So it is, I suggest, with alleged abductees, visionairies of Virgin Marys, and so on.

Consequently, I am very dubious of the 'as-if' approach taken by Hopkins, Jacobs, Sprinkle et al, just as I am dubious about theologicals who work from the premise that the Virgin Mary did really come down and chat with Bernadette. So while I'm all for your effort at building a network of 'caring professionals' I would also like them to be informed professionals -- informed, that is, of the infinite capability for self-deception displayed by humankind.

Stanton Friedman

79 Pembroke Crescent
Fredericton, New Brunswick E3B 2V1
Canada
(506) 457-0232

B.Sc. and M.Sc. (Physics) 1955, 1956, University of Chicago.

1956-1970 Industrial nuclear physicist, working on large scale classified programs for General Electric, Westinghouse, General Motors, TRW and Aerojet General; development of nuclear aircraft, fission and fusion rockets, nuclear power plants for space applications.

1970-1982 Full-time speaker (over 600 colleges, dozens of professional groups in all 50 states and 8 Canadian provinces)

1982-1990 Lecturing, broadcasting and consulting to industry on a wide range of technological topics including food irradiation, waste heat recovery at power plants, use of electron accelerators in industry, treatment of flue gas with electron beams to reduce acid rain, and all aspects of the RADON problem. Many invited conference papers.

Stanton offers a "dynamic, illustrated up-to-date program covering 5 large scale scientific studies, saucer landing, abductions, star travel, the crash and recovery by the military of an alien craft outside Roswell, New Mexico, in 1947, and recently obtained Top Secret documents clearly establishing that the subject of UFOs is a Cosmic Watergate."

"After 32 years of study and investigation, including hundreds of hours at various archives, he is convinced that

1. SOME UFOs are alien spacecraft.
2. The government has known this to be true since 1947.
3. None of the arguments made by the sceptics can stand up under careful scrutiny.
4. Alien visits are THE biggest story of the past millenium."

Stanton has appeared on hundreds of radio and TV programs across North America; he was heavily involved in the documentary UFOS ARE REAL and most recently his Roswell work was featured on UNSOLVED MYSTERIES.

Stan operates a 900 number called UFOLINE (1-900-USA-UFOS; $2 for first minute, $1 per minute thereafter), updated weekly with news on the following:

Recent sightings; Cosmic Watergate; UFO Abductions; Roswell Saucer Crash; Leave a Sighting Report; Myths about UFOs; Physical Evidence; Saucer Technology; and UFO Literature and Reports.

He also distributes some literature on this area, a list of which is available for a SASE. Some titles are:

Flying Saucers and Physics by Stan ("provides details on why UFOs do NOT violate the laws of physics, in star travel or air flight").

The Zeta Reticuli Incident by Terence Dickinson (reprint of his 1974 ASTRONOMY article) and The Zeta Reticuli Update which deals with objections to the Incident article.

The Cosmic Watergate by Stan ("story of the government coverup").

Jean Mundy

33 Windward Lane
East Hampton, New York 11937

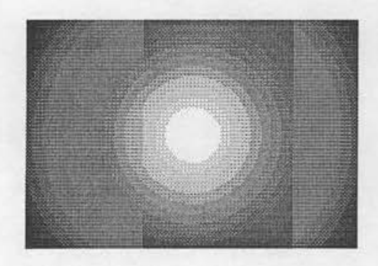
I'm a retired Professor of Psychology who has maintained a private practice of psychotherapy over the years. Since Whitley's book I've added a new specialty, therapy with abductees, with or without hypnosis. I believe that my clients have had direct contact with alien life forms, or at least a manifestation of some non-human energy. I've not seen a Gray, but have had a UFO sighting, and so many manifestations of the paranormal that I am convinced that what we see is the smaller part of what is out there.

Professionally I'm a licensed psychologist and have taken the only available professional course in hypnosis in NYC. In my work I find that the practice of Neuro-Linguistic Programming and Gestalt principles are the most helpful in reducing the effect of UFO trauma.

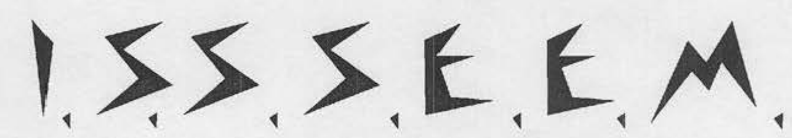
After giving up trying to bridge the cultural conditioning gap between the typical American and my contactees by the usual route of lectures and publications, I moved to two new forms of communication. I wrote a short cartoon book called "ET Manual" with humans as the Aliens, and I wrote a play "Believe Me!" about how a UFO sighting disrupts a military family. My play is about to be produced in a Community Theatre in Fairfield, Conn.

UFO sighting disrupts a military family. My play is about to be produced in a Community Theatre in Fairfield, Conn.

I like your newsletter, didn't like the name Ratchet, because anyone who survives in this field MUST have an OPEN mind, not a ratchet mind. BAE is better, but a bit stuffy. Difficulty of finding a name highlights that we don't even have an adequate vocabulary to talk/think about these experiences. I bristle every time I ask a book store clerk for "your UFO books" and am directed to the OCCULT section. Ought to be in the SOCIOLOGY/ANTHROPOLOGY section. Well, some day the Cosmic Watergate will be spilled.



Projects We Should Know About #1



ISSSEEM

International Society for the Study of Subtle Energies and Energy Medicine

C. Penny Hiernu, Executive Director
356 Goldco Circle
Golden, Colorado 80401
(303) 278-2228

The Organization

ISSSEEM is an interdisciplinary society for the study of informational and energetic interactions. The society is concerned with the study of informational systems and energies that interact with the human psyche and physiology, either enhancing or perturbing healthy homeostasis. A quarterly newsletter will be published, and a journal titled SUBTLE ENERGIES AND ENERGY MEDICINE: An Interdisciplinary Journal of Informational and Energetic Interactions.

The Society was informally organized last September by clinical psychologist Carol Schneider, biomedical engineer T.M. Srinivasan, anthropologist Stephan Schwartz, and Elmer Green, a psychophysiologic researcher. The journal of the Society was independently planned several months ago by Stephan Schwartz and others. Ms. C. Penny Hiernu, a professional in the field of society development, management, and activities, is Executive Director. The first annual meeting of the Society will be held in Colorado from June 21-23, 1991, with related workshops to be held on June 24 and 25.

They report a membership of over 1400.

Their Sphere of Interest

ENERGY MEDICINE includes all energetic and information interactions resulting from self-regulation or brought about through other energy couplings to mind and body. In addition to various therapeutic energies which we may use, there are also energy pulses from the environment which influence humans and animals in a variety of ways (eg. magnetic, electric, electromagnetic, gravitational).

In addition to energies originating in the environment, it has been documented that humans are capable of generating and controlling subtle not-yet-measurable energies that seem to influence both physiologic and physical mechanisms.

Compared with "energy medicine," the concept of SUBTLE ENERGY is more difficult to discuss in a scientific paradigm. the traditional subtle energies referred to as chi (or ki), prana, etheric energy, fohat, orgone, odic force, mana, homeopathic resonance, etc., are said to move in the so-called etheric body (subtle body), and seem to be difficult to measure at present. A number of therapeutic methods prevalent today, however, appear to be concerned with facilitating the flow of these subtle energies through the dense physical body.

In addition, it is traditionally accepted that expansions of consciousness often are related to changes in subtle energies that cannot be quantified. These latter "energies," which are said to be associated with interactions and with transcendence, may not, in fact, actually be involved with known physical fields.

Understanding and facilitating the use of subtle energies, both for therapeutic purposes and for the study of human potential, will perhaps open up to consciousness new (albeit traditional) depths of the human mind. If this should indeed be the case, one task of the Society will be to find and bring together those who are capable of synthesizing the two major interests of humankind, Natural Science and the transpersonal aspects of the human psyche. In modern jargon, this might include, though not be limited to, full integration of left cortex and right cortex with deeper brain centers.

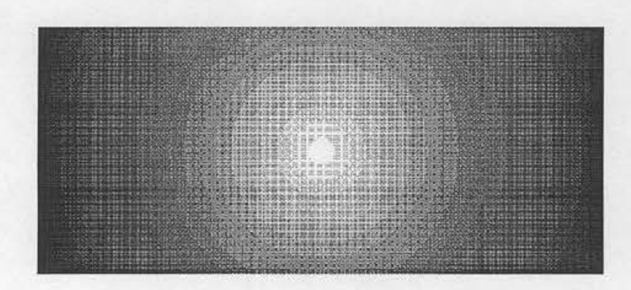
(the above is reproduced from their information brochure)

Vol 1, No. 3 of their Newsletter contains an interview with Robert O. Becker, M.D., who has been prominent in investigating the effects of electromagnetic fields on

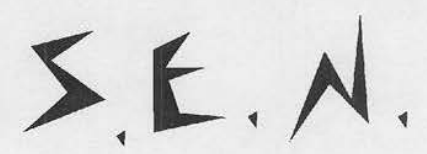
biological systems. He feels the control systems of the body are sensitive to electromagnetic fields (even low level, 60-Hz type) and these fields should be studied. He goes further to say that "a significant and essential aspect of regulation in the living organism is an ability to sense the normal electromagnetic factors. The question is, how is it done, where is it done, etc...for instance, we know the pineal as well as some other brain areas are magnetically sensitive. I suspect that some crucial experiments either have been done and not published, or have been refused for publication because of implications."

An article on research issues and instrumentation in subtle energy work highlights, among other issues, the importance of providing strict control procedures to overcome scepticism within the health profession without having adverse effects on the experiments themselves.

There is also an article by Willis Harman of the Institute of Noetic Science titled "On the Shape of a New Science." Harman talks about traditional science's limitations in dealing with anomalous events and the need to adopt new paradigms.



Projects We Should Know About #2



Spiritual Emergence Network
250 Oak Grove Avenue
Menlo Park, California 94025

My first exposure to the SEN was in a lecture delivered by a local physician on Spiritual Emergence Syndrome, a term applied to a broad group of intense spiritual experiences. The speaker included UFO abduction experiences in her list of manifestations of Spiritual Emergence Syndrome.

The orientation of the SEN can be appreciated from the blurb in their journal, called (naturally) the Spiritual Emergence Network Journal:

The SEN was created in 1980 in response to increasing number of people having intense spiritual experiences and seeking understanding, support and assistance. The central SEN office in Menlo Park, California is an education, training and information-providing facilty. It is not equipped to offer therapy for people in spiritual emergency. Its task is to disseminate theoretical information related to assisting people in spiritual crisis, to provide training, to mediate contact among interested persons, to create an international network, and to offer referral information.

SEN is a non-profit service organization. It represents an internationally oriented effort to offer a new understanding and approach to a specific category of emotional disorders that traditional psychiatry treats as diseases of unknown etiology and thus as medical problems. The SEN activities are based on the notion that these particular states can be understood and treated more effectively as complications of a transformative and evolutionary process -- as "spiritual emergencies" or transpersonal crisis.

The networking and referral functions of SEN, which serve over 10,000 people currently, are sustained by contributions and membership dues. Volunteers take phone calls and respond to mail inquiries.

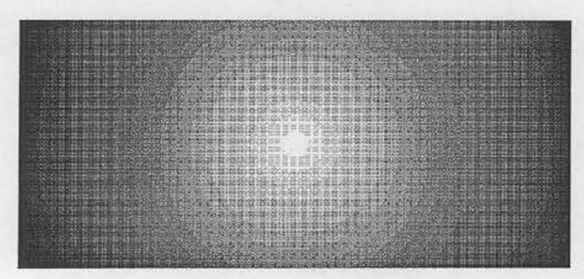
SEN draws heavily on the concepts of transpersonal psychology, as well as Kundalini Yoga. Their reading lists includes three titles by Stanislav Grof (PRINCIPLES OF HOLOTROPIC THERAPY, among others). The contents of their Fall 1990 journal give you a further idea of their direction:

For the Moment of Death by Sogyal Rinpoche describes "the pattern of spiritual experiences we undergo at the moment of death, and how to integrate these into our growth towards ultimate, complete union with God-Consciousness."

The Impoverished Soul: Addiction As Spiritual Emergency by Christina Grof

Notes on Mid-Life Crisis as Spiritual Emergence by Karen Turner, MFT

The Function of Creativity In Human Spiritual Development by Judith Cornell, Ph.D.



Projects We Should Know About #3

S.L.I.D.E.

SLIDE - Street Lamp Interference Data Exchange

59 Tranquil Vale
London SE3 OBS England

(The following is reproduced from the SLIDE information brochure provided by Hilary Evans)

"Elation! I had no idea so many other people have experienced the phenomena..." "I thought I was the only one to ever experience this..." "I was thunderstruck -- I have this problem but had no idea it was widespread enough to be a phenomenon!"

Such comments are typical of those SLIDE is receiving in response to the first announcement of our project. Evidently, a great many people have experienced SLI, never guessing that it was anything other than something weird that happened to them alone.

Such response suggests that STREET LAMP INTERFERENCE -- the experience of seeming to cause street lamps to go on or off -- is sufficiently widespread to constitute a phenomenon in its own right. However, it is only one kind of experience which seems to involve interaction between the human mind and the physical environment. (Other examples are poltergeist phenomena and various forms of psychokinesis.) Because there is no known mechanism whereby these things could occur, orthodox science is rarely willing even to contemplate the possibility, let alone explore the claims. Yet the testimony that such things happen is impressive.

SLI is especially suitable as an 'access point' to this interaction, because it is so open and explicit. The possibility that witnesses tamper with public lamps is negligible, so SLI isn't open to charges of trickery in the way mental-bending or dice-rolling, say, are questionable. And the event itself is unambiguous -- either the lamp is turned off or on, or it isn't.

From that point on, of course, the questions come thick and fast; and indeed it was the fact of people coming up to me after lectures and questioning me about what was happening to them, and of others writing letters in anomaly journals asking for guidance, which encouraged me to set up PROJECT SLIDE.

At this preliminary stage, the aim is simply to gather a body of reports so we can get the phenomenon in some kind of perspective, and to provide a forum where those who have experienced SLI and those who research such anomalies can work together towards an understanding of what is happening.

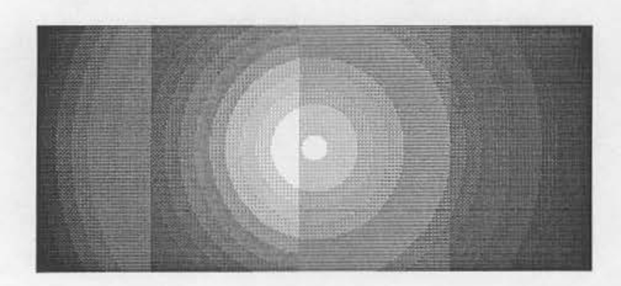
How widespread is SLI? Already, it is clear that SLI occurs far more frequently that anyone has suspected. Equally, there are many indications that what we learn from studying SLI will have implications for many other kinds of anomalous behaviour: Many accounts contain hints of fascinating correlations with 'electric sensitive' people, people who stop clocks, who cause electronic devices to malfunction and so on -- in short, all kinds of interaction, seemingly at the subconscious level, with the physical environment.

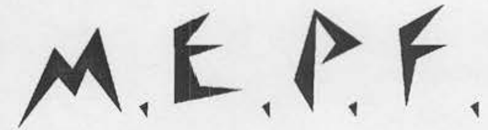
At this stage, SLIDE is no more than an informal network of interested people, whose experiences and ideas are published from time to time -- two or three times a year -- in a not-too-formal bulletin SLIDINGS. There is no formal subscription; but if you wish to contribute towards the cost of photocopying and mailing, it would be welcome; $10 or equivalent for overseas (banknotes preferred). (Larger donations will of course be put to good use!)

What type of data is needed? The trouble is, it's impossible to say what would be relevant; so many factors might play a part -- the state of the weather, the state of one's health or one's emotions. The powers of 'electric girl' Angelique Cottin peaked nightly between 6pm and 8pm; why? I like SLIder Dean Slawson's suggestion, "My wife and I purchased a dog in April, which ought to be about as relevant as any of the rest of these data!"

Two things seem to be clear already. First, SLI happens: Too many people have sent in detailed accounts for coincidence to be an acceptable explanation. And second, there is no simple answer: Suggestions such as car headlights triggering light-sensitive devices are inadequate to explain how a witness can experience SLI when he's driving, but when his wife drives the same vehicle she doesn't; or how another witness can experience SLI not only when driving but also when cycling or walking the dog.

If you have SLI or SLI-related experiences to report, or if you have any thoughts about what may be gong on, I invite you to participate in SLIDE. Unless you indicate otherwise, it is assumed you are happy for your experiences to be published and your name to be mentioned; but if you wish confidentiality, of course you may have it.





Mystical Experiences
With Psychotic Features

The excerpts below from a paper in the Journal of Transpersonal Psychology, have much we can draw from. It elegantly puts forward an argument for the justification of creating a new diagnostic category, and places it in the context of other known (though not necessarily well-understood) phenomena. From a practival pointof view, the definition of the syndrome is clear, concise, and useful for data collection and therapy. It also speaks to mainstream medicine and psychiatry in particular in their own language.

There is some overlap between the phenomenology of the abduction syndrome and MEPF, though of course one of the most obvious differences is that psychosis is not associated with the former. That some have suggested a kinship between abduction and mystical experiences in general is yet another reason I thought this would be worth presenting.

THE DIAGNOSIS OF MYSTICAL EXPERIENCES WITH PSYCHOTIC FEATURES

David Lukoff

Journal of Transpersonal Psychology, 1985, Vol. 17, No. 2

This paper presents a model delineating the overlap between mystical experiences and psychotic states, and suggests guidelines for making diagnostic and treatment decisions from a psychiatric perspective which recognizes this overlap.

Need For A New Diagnostic Category

Diagnosing cases as Mystical Experience With Psychotic Features (MEPF) requires the defining of a new diagnostic category. Wing, a respected authority on diagnosis, noted that

> to put forward a diagnosis is, first of all, to recognize a condition, and then to put forward a theory about it. Theories are meant to be tested. The most obvious test is whether applying the theory is helpful to the patient. Does it accurately predict a form of treatment that reduces disability without leading to harmful side-effects?

Criteria for MEPF: Overview

1. Satisfies DSM-III definition of "psychotic."
2. Satisfies 5 criteria below for overlap with mystical experience.
3. Positive outcome likely
4. If low risk, define as MEPF. If not a low risk, defer dx until crisis resolved, then reassess risk and diagnosis.

Overlap With Mystical Experience

The following five criteria, which must all be present, constitute a template for the mystical experience:

A. Ecstatic mood. The most consistent feature of the mystical experience is elevation of mood. Laski (1968) describes it as a state with "feelings of a new life, another world, joy, salvation, perfection, satisfaction, glory" James points to the "mystical feeling of enlargement, union and emancipation" and claims that "mystical states are more like states of feeling that states of intellect."

B. Sense of newly-gained knowledge. Feelings of enhanced intellectual understanding and the belief that the mysteries of life have been revealed.

C. Perceptual alterations, ranging from heightened sensations to auditory and visual hallucinations.

D. Delusions, if present, have themes related to mythology.

James and Neuman have both commented on the diversity of content in mystical experiences across time and cultures. The mystical experience does not have "specific intellectual content whatever of its own. It is capable of forming matrimonial alliances with material furnished by the most diverse philosophies and theologies."

Perry points out that below the surface level of specific identities and beliefs are thematic similarities in the accounts of patients whose psychotic episodes have good outcomes. Based on his research and other accounts of patients with positive experiences, the following eight themes were identified as occurring commonly in MEPF:

1. Death: being dead, meeting the dead or meeting Death.
2. Rebirth: new identity, new name, resurrection, apotheosis to god, king or messiah.
3. Journey: Sense of being on a journey or mission.
4. Encounters with spirits: demonic forces and/or helping spirits.
5. Cosmic conflict: good/evil, communists/americans, light/dark, male/female.
6. Magical powers: telepathy, clairvoyance, ability to read minds, move objects.
7. New society: radical change in society, religion, New Age, utopia, world peace.
8. Divine union: God as father, mother, child; Marriage to God, Christ, Virgin Mary, Radha or Krishna.

E. No conceptual disorganization. Some psychotic patients have cognitive deficits which cause them difficulty with their basic thought processes. Systematic

comparisons of mystical experiences and schizophrenia have found that thought blocking and other disturbances in language and speech do not appear to accompany the mystical experience. Therefore, the presence of conceptual disorganization, as evidenced by disruption in thought, incoherence and blocking, would preclude assigning a psychotic episode to the MEPF category. However, delusional metaphorical speech which may be difficult to understand, but is comprehensible, should not be considered conceptually disorganized.

Positive Outcome

At least two of the following four criteria predictive of positive outcome must be present:

1. Good pre-episode functioning as evidenced by no previous history of psychotic episodes, maintenance of a social network of friends, intimate relationships with members of the opposite sex (or same sex if homosexual), some success in a vocation or school.

2. Acute onset of symptoms during a period of 3 months or less (Six months or longer onset is associated with poor outcome).

3. Stressful precipitants to the psychotic episode such as major life changes: a death in the family, divorce, loss of job (not related to onset of symptoms), financial problems, beginning a new academic program or job. Major life passages which result in identity crises, such as transition from adolescence to adulthood, should also be considered.

4. Positive exploratory attitude toward the experience as meaningful, revelatory, growthful. Research has found that a positive attitude toward the psychotic process facilitates integration of the experience into the person's post-psychotic life.

Low Risk

Psychotic disorders can be the basis for homicidal and suicidal behaviors. Strictly speaking, the level of risk to self or others is not a diagnostic question. However, it has important implications in the area of treatment.

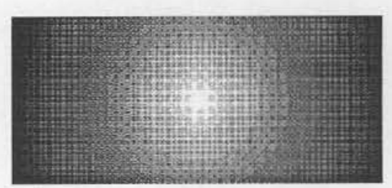
This exclusionary criterion should be implemented only if the danger seems immediate and severe. Behavior which appears bizarre, but presents no risk to self or others, does not warrant use of this criterion.

Conclusion

The incidence of MEPF cases treated in hospital environments designed to suppress mystical experiences is not known. The adoption of operational criteria for identifying these individuals will lead to more accurate identification of these cases. In turn, this would promote the development of more effective treatments which allow them to continue on and return from inner journeys with their lives and psyches intact or improved.

To evaluate psychotic experiences with regard to evidence of growth potential is not necessarily to be over-optimistic about the phenomenon of psychosis. It may allow us to be more precisely optimistic when the clinical data warrant, however, and urge us to re-examine our therapeutic strategies so that we foster growth whenever possible.

To traditionally-trained mental health professionals, the proposition that some psychotic episodes are growthful may seem to be wishful or even magical thinking. Yet, the diagnostic approach suggested in this paper adheres to the existing diagnostic practices within the mental health field. It utilizes operational criteria based on empirical studies to identify a group of persons likely to have positive outcomes following psychotic episodes.





Alternate States of Consciousness

Hilary Evans
Surrey: Aquarian Press, 1989

Hilary Evans' contributions to this issue emphasize the importance of having a thorough grounding in the existing knowledge base of anomalous experience. This book is one of the most accessible volumes on the subject for the layman that I have yet encountered. It is both comprehensive and easily digestible.

His book is divided into discussion of the different types of ASCs (spontaneous, externally triggered, mentally triggered and "voluntary"); triggers (physiological, environmental, psychological and cultural); motives (conscious and unconscious); and the benefits and costs of experiencing ASCs.

It is probably not easily available on bookshelves in North America -- I had to order it through Arcturus Book Services (P.O. Box 831383, Stone Mountain, GA 30083-0023). Highly recommended.



In previous issues we have already discussed temporal lobe epilepsy. In the last round of correspondence one reader suggested a review of the broader subject of complex partial seizures would be helpful. So, in an ongoing effort to bring us all up to speed on the differential diagnosis of anomalous experience, here is the best review I could put together of the subject, largely (though not exclusively) culled from the reference below.

Complex Partial Seizures

George B. Murray, MD

from Psychiatric Medicine Update: Massachusetts General Hospital Reviews for Physicians

by Manschreck, T.C. Editor-in-Chief. 1981: Elsevier Science Publishing Company.

Introduction

Strange or bizarre behavior may be an expression of a seizure disorder. Indeed, psychiatric presentation is not unusual for patients with partial complex seizures. This diagnosis is missed by both neurologist and psychiatrist, as neither specialist may appreciate "atypical" features of temporal lobe, psychomotor, or, according to more recent classification, complex partial seizures.

Terminology

SEIZURE is a transient, paroxysmal, pathophysiological disturbance of cerebral function caused by a spontaneous, excessive discharge of cortical neurons. The clinical manifestations of a seizure depends on the site of origin and the pattern of spread of the discharge.

GENERALIZED SEIZURES are bilaterally symmetric, and without local onset; contrast this with

PARTIAL SEIZURES, where the seizure begins locally, and may (or may not) become secondarily localised.

Partial seizures can be grouped into three categories:

- SIMPLE (without impairment of consciousness)

The keynote of a simple partial seizure is some elementary symptomatology, for example a sensation of itching or crawling underneath the skin.

- COMPLEX (with loss of consciousness). Here the initial symptoms are not as extensive as generalized epileptic seizures.
- with secondary generalization

ABSENCE A very brief clouding or loss of consciousness lasting about 1-15 sec. Absence known to be from the temporal lobe is called an absence of temporal lobe epilepsy. The clear diagnosis of a generalised absence seizure as opposed to an absence of temporal lobe is important; atypical and typical petit mal absences respond to quite different anticonvulsant medication than does the absence of temporal lobe seizure.

PETIT MAL Simple or complex absence accompanied in the EEG by a bilateral, synchronous, and symmetrical discharge or rhythmic 3/sec spike-wave complexes. It is rare for a person over 20 to have the first occurence of petit mal.

TEMPORAL LOBE EPILEPSY. Epileptic seizures, regardless of symptoms, in which the neuronal discharge or the lesion provoking it has been objectively confirmed by EEG or other means as situated in the temporal lobe. More generally, the term TLE usually embraces seizures with automatisms and amnesia and psychic seizures with subjective pheomena such as hallucinations and illusions.

PSYCHICIAL SEIZURES. A type of partial epileptic seizure with complex psychic symptoms, such as hallucinations, that results from neuronal discharge in the associative cortex of the temporal lobe or, rarely, the frontal lobe. In the United States this term is used infrequently by neurologists.

Ictal Characteristics Of Complex Partial Seizures

Classically, a patient experiencing a complex partial seizure may present in the following way: The episode may have been preceded by an aura, automatic behavior, or automatism consisting of picking at the clothes, walking over to a table, moving a glass and coming back, a glazed look in the eyes, unilateral or bilateral muscular movement (eg head turning and lipsmacking). The patient would generally have amnesia for the event. The physician would probably diagnose complex partial seizure if the patient were seen with automatisms and amnesia and had an appropriate history.

In general, there are five elements usually found in ictal behavior of the complex partial seizure:

- memory disturbances,

- hallucinations,
- egocentricity,
- forced thinking (an intense focusing of attention on some object),
- automatism.

There is usually some loss of memory or an inability to lay down new memory traces during the ictal events. Some physicians have used this feature, amnesia for the ictal events, as a rule of thumb to determine whether the episode was true epilepsy or hysteria (pseudoseizure). The contention, in practice, is that if the patient remembers anythng from the episode, it is hysterical, because by definition automatic behavior and amnesia remove the possibility of memory. More correctly, there are usually islands of memory during an ictal event in complex partial seizures.

Automatism is one of the key presentations of ictal behavior. It is defined the state in which an individual is able to move about in a relatively normal manner, and is, at the same time, suddenly lacking in understanding...subsequently he will have amnesia for the period. He may seem to be an automaton and yet is sometimes partially receptive of directions from another.

Interictal Characteristics Of Complex Partial Seizures

Though it is not always clear how to distinguish clinically between a person in the ictal and one in the interictal state, an "interictal behavior syndrome" has been described which has five characteristics:

1. DAY-TO-DAY VARIABILITY: Patients seem unstable in character, with heightened emotionality; on one day patients may be euphoric and on the next day depressed or angry.

2. IRRITABILITY, often expressed as agression towards objects (and infrequently towards other people). There is an "on-off" quality about their irritabilty--having explosive, temperamental outbursts alternating at the next moment with an unctious good-naturedness. It is this characteristic more than any other that gives the person with nonclassical-appearing complex partial seizure the high probability of being diagnosed as having borderline personality organization.

3. RELIGIOUSITY. The patient may be interested in God, and may have abstract philosophical interests in the world, mankind, social justice, law and order, and related philosophicoreligious subjects. There is heightened emotion when a patient speaks of these elements and he often sounds righteous and religious.

4. HYPOSEXUALITY (decreased libido)

5. EXCESSIVE CONCERN WITH TRIVIAL EVENTS, HYPERGRAPHIA, AND VISCOSITY ("stickiness") Circumstantiality and excessive concern with trivial events often leads the patient to write down just about everything -- they will have volumes of poetry, write novels, keep a daily diary, or write voluminous letters.

Infrequently these patients have interictal hallucinations, a phenomenon which can cause them to be diagnosed as schizophrenic.

The EEG

The EEG is one of the most important aids to diagnosis of complex partial seizure. An awake EEG is better than no EEG at all, but if complex partial seizure is suspected, it saves time and expense to go right to the sleep EEG. The sleep EEG is helpful in increasing the chances of finding abnormalities in the suspected complex partial seizure patient. An EEG at a given time is only a sampling, and a normal awake EEG does not rule out complex partial seizure.

In general, an abnormal EEG with temporal spikes tends to confirm the suspicion of complex partial seizure. Sharp or slow activities tend to increase the suspicion. But the diagnosis of a seizure is a clinical diagnosis, not an EEG diagnosis. The appearance of an isolated spike in the temporal region does not in itself indicate complex partial seizure. Ideally, one needs signs, symptoms, and EEG manifestations to make a hard diagnosis of complex partial seizures.

The use of nasopharyngeal leads is another story, in that some community EEG laboratories do not use them and even in larger institutions one encounters dificulty in ordering them. Problems: Not all technicians are trained in placing them, it takes more time to place these leads, the patient may balk at them, and at the slightest excuse the technician may defer using them. Also, many electroencephalographers are of the opinion that nasopharyngeal leads, for the amount of time and attention they require, give no increase in yield. Others feel that they are important if one suspects complex partial seizure, especially if in the symptoms that form the basis for suspicion are the so-called psychic elements as opposed to automatisms and amnesia.

Diagnosis

There are three areas from which to draw in making a diagnosis: Signs, symptoms, and EEG. The four possibilities, and Dr. Murray's treatment recommendation are:

1. Symptoms, signs, and an abnormal EEG

-trial of anticonvulsant medication, and neurological workup to look for a possible cause of the seizure.

2. Symptoms, signs, and a negative EEG

-trial of anticonvulsants

3. Symptoms, no signs, and an abnormal EEG

-trial of anticonvulsants

4. Symptoms alone with a negative EEG

-if the EEG were an awake EEG, a sleep or repeat EEG would be in order before an anticonvulsant trial.

-if the patient has no previous psychiatric history, and shows no affective or cognitive illness (i.e. rule out that the psychic phenomena are secondary to other psychiatric illness), there may be ground for suspicion of complex partial seizures. Whether a clinical trial of anticonvulsants should be conducted would usually depend on two things: Whether the patient had previously tried psychotropic medications with success, and how intensely the patient presents with these symptoms.

Treatment

Carbamazepine (Tegretol) appears to be superior for complex partial seizures, and is also being investigated in affective disorders, as it may be one of the few anticonvulsants that check "kindling" in the limbic system. Baseline blood studies should be taken before starting carbamazepine, because hemopoietic suppression may occur with its use. Other choices are phenytoin, primadone, phenobarbital, clonazepam and valproid acid.

Does adequate anticonvulsive therapy eliminate so-called interictal psychosis? Occasionally, but not always. If the patient is given adequate anticonvulsants and has found benefit from them but still has hallucinations or illusions, one can treat those with psychotropic medication, usually neuroleptics. The patient usually requires a smaller dosage of neuroleptics for hallucinations than does the schizophrenic with hallucinations.

Psychotherapy may be very helpful to the patient with complex partial seizures. Most helpful is psychotherapy that is supportive, explanatory, and demonstrating that the therapist understands the "weirdness" that the patient experiences. This psychotherapy is best done by a physician who is conversant with partial seizures, as most of the concerns and questions that the patient will have center around his abnormally firing brain.

